

DOCUMENT RESUME

ED 149 506

EC 103 578

TITLE Taking Charge: Coordinating Clinical and Educational Information About Your Handicapped Child.

INSTITUTION National Learning Resource Center of Pennsylvania, King of Prussia.

SPONS AGENCY Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.; Pennsylvania State Dept. of Education, Harrisburg. Bureau of Special and Compensatory Education.

PUB DATE 77

CONTRACT OEC-0-74-7892

NOTE 54p.; For related information, see EC 103 572 - EC 103 577

EDRS PRICE MF-\$0.83 HC-\$3.50 Plus Postage.

DESCRIPTORS Educational History; Family Background; *Handicapped Children; Medical Evaluation; Psychological Evaluation; *Records (Forms)

IDENTIFIERS *Parent Resources

ABSTRACT

Intended for parents of handicapped children, the workbook provides forms for keeping track of children's progress. Nine forms are included for recording the following information: identifying information, birth history, developmental history, medical history, family background, educational history, psychological information, special services information, and calendar of professional contacts. (SBH)

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Taking Charge:

Coordinating Clinical
and Educational Information
About Your Handicapped Child

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of Pennsylvania
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The National Learning Resource Center of Pennsylvania is a federally funded contract between the Bureau of Education for the Handicapped, Washington, D.C., Contract #OEC-0-74-7892, and the Bureau of Special and Compensatory Education, Pennsylvania Department of Education. The contract is administered by Montgomery County Intermediate Unit #23. The opinions expressed herein do not necessarily reflect the position or policy of the Pennsylvania Department of Education or the Bureau of Education for the Handicapped.

NLRC/P gratefully acknowledges the support and contributions of the following persons and institutions under whose auspices this document was developed.

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Taking Charge

As parents of a handicapped child, you have the responsibility of monitoring development and care. You should be aware of your child's needs so that you can be sure they are being properly met. Your child cannot determine whether he is getting appropriate treatment from the professionals he sees, and it is up to you, as his parents, to take charge.

To do this effectively, you will need to keep careful records of your child's development and treatment program. As you contact various professionals over a period of time, you will need to provide them with information about your child's developmental history, so that they can do their best to help him. To insure that you don't forget any of this information, it is essential that you write down what happens to your child at each step in his development and treatment.

How do you know what types of information to record? This workbook includes forms to help you keep careful track of your child's progress. If you use these forms, you will always have the necessary information at your fingertips. It will be invaluable to you as you contact the various professionals who can help your child.

This workbook contains nine forms for recording certain personal information. At some point during your child's treatment, you may find that ready access to this information will be important. However, these forms are specifically intended for your own use, and the information you record is for your eyes alone. You will decide when and if it is appropriate to share your records with professional service people. No one need ever see what you have written unless you decide to show it to him.

The first six forms are for recording background information, and these should be filled out before you begin seeking professional help for your child. These forms are long and detailed, so fill them out when you have plenty of time. Once you have completed them, simply take the workbook with you when you visit professionals. By referring to what you've recorded on these forms, you will be able to supply professionals with the background information they need about your child.

The last three forms (Psychological Information, Special Services Information, and Calendar of Professional Contacts) are for you to use after a visit with a professional who is treating your child. Use these forms to record your impressions of what happened during the sessions, and to note any information about the visit that you will need for future reference. Try to fill out these forms immediately after a professional contact, so that you will not forget any details of the visit. Since your child will probably see a number of different professionals at one time or another, you will need more than one copy of these last three forms. For your convenience, extra copies are included in the workbook, and you can xerox additional copies on the copying machine at your local post office or library. Keep the blank copies of these forms in your workbook so that you will always have them at hand.

Remember that the effort you put into keeping careful records of your handicapped child is a crucial part of insuring that he receives all the special care he deserves. Careful and complete records will support your requests for special services, and will keep professionals aware of changes in your child's condition as he grows and develops.

On this form, please record basic background information concerning your family and your handicapped child.



IDENTIFYING INFORMATION

Page 1

Full name of child: _____ Date of Birth: _____

Address: _____ Home Phone: _____

School: _____ Grade: _____

School Address: _____

Full name of mother: _____ Date of Birth: _____

Mother's religious preference: _____

Full name of father: _____ Date of Birth: _____

Father's religious preference: _____

Mother's occupation: _____ Business telephone: _____

Father's occupation: _____ Business telephone: _____

Siblings:

	<u>NAME</u>	<u>BIRTHDATE</u>	<u>GRADE IN SCHOOL</u>	<u>LIVING AT HOME?</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Other Persons in home:

	<u>NAME</u>	<u>AGE</u>	<u>HEALTH</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

IDENTIFYING INFORMATION

Page 2

Contact in absence of parents in case of emergency:

Name: _____

Address: _____ Phone: _____

Relationship: _____

Hospital to be used for emergency: _____

Health and Accident Insurance Information:

<u>NAME</u>	<u>POLICY #</u>	<u>DATE ISSUED</u>	<u>COMPANY</u>	<u>TYPE OF COVERAGE</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

On this form, please record details relating
to your handicapped child's birth and his
early medical history.

FORM 2:
BIRTH HISTORY



BIRTH HISTORY

Page 1

Background Information

Mother's age at birth of child: _____

Blood types: Mother _____ Father _____ Child _____

PKU test: Mother _____ Father _____ Child _____

Previous pregnancies: _____ Subsequent pregnancies: _____

Number of miscarriages: _____

This Pregnancy

Length of Pregnancy: _____ Hospital: _____

What medications did you receive? _____

Any vaginal bleeding? _____ How long? _____

During this pregnancy, did you experience:

Spotting _____	Diarrhea _____	Illnesses _____
Exposure to X-ray _____	Surgery _____	Exposure to contagious _____
Rashes _____	Excessive vomiting _____	diseases _____
High temperature _____	False labor _____	

Comments on above: _____

Did your doctor note:

High blood pressure? _____ Medication received (type) _____

Convulsions? _____ Medication received (type) _____

Fluid retention? _____ Medication received (type) _____

BIRTH HISTORY

Page 2

Did you have any serious accidents during pregnancy? _____

Please explain. _____

Birth Information

Birth weight: _____ Length: _____

Duration of labor: _____ Type of delivery: _____

Anesthesia used? _____

Any labor complications? _____

Any transfusion given? _____ Mother _____ Child _____

Did mother hear baby cry soon after birth? _____

Did baby require resuscitation? _____

Was baby in an incubator? _____ How long? _____

Did the doctor tell you why? _____

Postnatal Information

Length of hospital stay: _____ Mother _____ Child _____

Mother's postnatal health: _____

Did the baby seem to tremble or shake? _____

Any convulsions? _____ When? _____

Any evidence of jaundice? _____ If so, when was it evident? _____

How long did it last? _____

Any scars, deformities noted? _____

Was baby breast fed? _____ For how long? _____

Any problem sucking? _____ Chewing? _____ Swallowing? _____

BIRTH HISTORY

Page 3

Feeding problems: _____

Any drug sensitivity? _____

Allergies: _____

This form follows all aspects of your handicapped child's development during his infancy and his early years of childhood.



DEVELOPMENTAL HISTORY

Page 1

Feeding history: _____

Sleep history: _____

Note age at which your child accomplished the following:

- | | | | |
|------------------------|-------|-------------------------------------|-------|
| 1. Hold head up | _____ | 11. Drink from glass or cup | _____ |
| 2. Smile | _____ | 12. Eat solid food with fingers | _____ |
| 3. Roll over | _____ | 13. Use a spoon | _____ |
| 4. Sit up alone | _____ | 14. Indicate need to use toilet | _____ |
| 5. Crawl | _____ | 15. Toilet trained – bladder | _____ |
| 6. Stand alone | _____ | Toilet trained – bowel | _____ |
| 7. Walk alone | _____ | 16. Complete care of self at toilet | _____ |
| 8. First tooth | _____ | 17. Dress himself | _____ |
| 9. First word | _____ | 18. Wash himself | _____ |
| 10. Put words together | _____ | | |
| Put phrases together | _____ | | |
| Put sentences together | _____ | | |

Date of last bedwetting: _____

Is bedwetting a problem? _____

DEVELOPMENTAL HISTORY

Page 2

Present functioning:

Ambulation (crawl, walk, run, hop, skip, climb, use a tricycle): _____

Manipulative ability (grasp, hold, lift, carry, release, push, pull): _____

Any separations from family? _____

When? _____

Reasons: _____

Does child have any unreasonable fears or worries? _____

Describe. _____

Temper tantrums? _____ At what age? _____

List any undesirable habits (biting fingernails, etc.): _____

DEVELOPMENTAL HISTORY

Page 3

Describe any traumatic or unusual experiences. _____

Additional Comments: _____

This form provides a place for you to record important information concerning the medical history and treatment of your handicapped child, including the types of medication he receives.



MEDICAL HISTORY

Page 1

What specific diagnoses (if any) have been made by physicians? _____

Immunizations:

	<u>DATES</u>	<u>REACTION (Note temperature, if any)</u>
Smallpox	_____	_____
Whooping Cough	_____	_____
Diphtheria	_____	_____
Tetanus	_____	_____
Polio	_____	_____
Measles	_____	_____
Tuberculin test	_____	_____

History of contagious diseases:

<u>NAME</u>	<u>DATE</u>	<u>SEVERITY</u>	<u>TEMPERATURE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

Page 2

Describe any hospitalization.

Age: _____ Date: _____

Reason: _____

Any complications: _____

Has child ever received oxygen? _____ For what reason? _____

Any accidents? _____

Head injuries? _____

X-rays? _____

Allergies: _____

Has your child had the following conditions:

Motor difficulties _____

Nausea _____

Headaches _____

Fainting _____

Tics or nervous habits _____

Physical weakness _____

Bedwetting _____

Seizures or spells _____

Any current physical problems? _____

What other medical treatment recommendations have been made to you by your physician?

MEDICAL HISTORY

Page 3

Unusual reactions to medication or medical treatment of any kind: _____

Describe physical limitations on your child's play and learning activities:

Additional Comments: _____

Type of Medicine	What For	How Often	Dosage	Date Prescribed	Physician	Reactions

MEDICAL HISTORY

Page 4

On this form, please record information
which gives a picture of your family as a unit,
by describing each member in some detail.

FORM 5:
FAMILY BACKGROUND



FAMILY BACKGROUND

Page 1

PLEASE NOTE: This form includes questions concerning all areas of your family's background. Some questions may seem very personal to you. You may not wish to actually record your answers to some of the more sensitive questions out of a concern that other members of your family might, at some time, read what you have written. Therefore, fill out only those sections of the form that you wish to. However, you should be aware of the fact that all of these questions are likely to be asked by the professionals you will be seeing in reference to helping your handicapped child. Even if you do not record all of your answers to the more personal questions on this form, have your answers ready in your mind before you visit professionals.

Maternal Information

Full name of mother: _____ Age: _____

Date of birth: _____ Place of birth: _____

Second language: _____

Was child adopted: _____ At what age? _____

Relationship to child: Mother _____ Guardian _____ Stepmother _____

Any previous marriage(s)? _____ Number of children from previous marriage(s): _____

Last grade of school mother completed: _____

Is mother employed? _____ Type of work: _____

Where? _____

What hours? _____

Note any problems in:

Mother's speech _____ Hearing _____

Is the mother left-handed? _____ Right-handed? _____

Eye difficulties? _____ Wears glasses? _____

Eye difficulties on either side of mother's family? _____

FAMILY BACKGROUND

Page 2

Since this child's birth, has mother had:

Serious illnesses? _____

Diseases? _____

Operations? _____

Serious accidents? _____

Nervous conditions? _____

Hospitalizations? _____

Institutionalizations? _____

Rh factor difficulties in mother's family? _____

Comments on above: _____

Mother's health history (also note as to mother's family):

Tuberculosis _____

Cancer _____

Venereal disease _____

Drugs _____

Epilepsy _____

Diabetes _____

Alcoholism _____

Mental illness _____

Comments on above: _____

Mother's emotional stability: _____

Describe briefly mother's present state of health. _____

FAMILY BACKGROUND

Page 3

Interests and hobbies: _____

Has mother been absent from home since birth of child? _____

When? _____ Why? _____

Paternal Information

Full name of father: _____ Age: _____

Date of birth: _____ Place of birth: _____

Second language: _____

Relationship to child: Father _____ Guardian _____ Stepfather _____

Was child adopted? _____ At what age? _____

Any previous marriage(s)? _____ Number of children from previous marriage(s): _____

Last grade of school father completed: _____

Is father employed? _____ Type of work: _____

Where? _____

What hours? _____

Note any problems in:

Father's speech _____ Hearing _____

Is the father right-handed? _____ Left-handed? _____

Eye difficulties? _____ Wears glasses? _____

Eye difficulties on either side of father's family? _____

FAMILY BACKGROUND

Page 4

Since child's birth, has father had:

Serious illnesses? _____

Diseases? _____

Operations? _____

Serious accidents? _____

Nervous conditions? _____

Hospitalizations? _____

Institutionalizations? _____

Comments on above: _____

Father's health history (also note as to father's family):

Tuberculosis _____

Cancer _____

Venereal disease _____

Drugs _____

Epilepsy _____

Diabetes _____

Alcoholism _____

Mental illness _____

Comments on above: _____

Father's emotional stability: _____

Describe briefly father's present state of health. _____

Interests and hobbies: _____

Has father been absent from home since birth of child? _____

When? _____ Why? _____

FAMILY BACKGROUND

Page 5

Family Information

All members of child's immediate family living and well? _____

Parents: Living together? _____ Separated? _____ Divorced? _____

Siblings:

	<u>NAME</u>	<u>BIRTHDATE</u>	<u>GRADE IN SCHOOL</u>	<u>LIVING AT HOME?</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Other persons in home:

	<u>NAME</u>	<u>AGE</u>	<u>HEALTH</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Languages spoken in home: _____

Any changes of residence since child's birth? _____

When? _____

Describe how child gets along with:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

FAMILY BACKGROUND

Page 6

What are your child's family responsibilities or chores? _____

Who disciplines the child at home? _____

Describe the discipline methods you have used, including rewards and punishments. _____

This form traces your handicapped child's educational experiences.



EDUCATIONAL HISTORY

Page 1

Present school: _____

Address: _____

Teacher: _____ Principal: _____

Current class or grade level: _____

List all schools and dates attended from preschool to present.

<u>NAME OF SCHOOL</u>	<u>LOCATION</u>	<u>GRADE LEVEL</u>	<u>DATES ATTENDED</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Exact age when child started:

Kindergarten _____ years _____ months

First grade _____ years _____ months

Any nursery school or small group experiences prior to first grade? _____

At what age? _____ Where? _____

Has child ever failed or repeated a grade? _____

From your child's last report card, list present subjects and grade received.

EDUCATIONAL HISTORY

Page 2

If achievement test results have been reported to you, list them below:

<u>NAME</u>	<u>DATE GIVEN</u>	<u>RESULTS</u>

List and comment on any special education, tutoring, speech or educational therapy and other remediation received.

When did you last talk with your child's teacher and/or principal about his learning problems? _____

How did the teacher describe your child's learning problems? What suggestions were made? _____

Note teacher's comments regarding your child's strengths and weaknesses in:

Physical Education: _____

Arts & Crafts: _____

Music: _____

Reading: _____

Writing: _____

Spelling: _____

Arithmetic: _____

Language: _____

EDUCATIONAL HISTORY

Page 3

What does your child like best in school? _____

What does your child like least in school? _____

This is a form to be filled out following a contact between your handicapped child and a psychologist. Please record information concerning the psychologist's evaluation and recommendations for treatment.



PSYCHOLOGICAL INFORMATION

Page 1

Name of psychologist who examined your child: _____

Address: _____

Phone: _____

Date of examination: _____

Who referred your child for examination? _____

Date of follow-up conference with the examining psychologist: _____

What tests were given? _____

Did the psychologist evaluate your child in these ability areas? What did he find?

1. Gross Motor Skills: (large muscle coordination & physical strength) _____

2. Sensory Motor Skills: (balance, motor accuracy, directionality, laterality) _____

3. Perceptual Skills: auditory: _____

visual: _____

visual-motor: _____

PSYCHOLOGICAL INFORMATION

Page 2

4. Language Development Skills: (vocabulary, reading, writing, spelling) _____

5. Conceptual Skills: (arithmetic, information, comprehension) _____

6. Social Skills: (ability to relate, self-control) _____

What recommendations were made concerning your child's school placement? _____

What recommendations were made to you (such as behavior modification, parent education, family counseling, medical supervision)? _____

What have you done about these recommendations? _____

Does the psychologist want to see your child again? _____

When? _____

PSYCHOLOGICAL INFORMATION

Page 1

Name of psychologist who examined your child: _____

Address: _____

Phone: _____

Date of examination: _____

Who referred your child for examination? _____

Date of follow-up conference with the examining psychologist: _____

What tests were given? _____

Did the psychologist evaluate your child in these ability areas? What did he find?

1. Gross Motor Skills: (large muscle coordination & physical strength) _____

2. Sensory Motor Skills: (balance, motor accuracy, directionality, laterality) _____

3. Perceptual Skills: auditory: _____

visual: _____

visual-motor: _____

PSYCHOLOGICAL INFORMATION

Page 2

4. Language Development Skills: (vocabulary, reading, writing, spelling) _____

5. Conceptual Skills: (arithmetic, information, comprehension) _____

6. Social Skills: (ability to relate, self-control) _____

What recommendations were made concerning your child's school placement? _____

What recommendations were made to you (such as behavior modification, parent education, family counseling, medical supervision)? _____

What have you done about these recommendations? _____

Does the psychologist want to see your child again? _____

When? _____

PSYCHOLOGICAL INFORMATION

Page 1

Name of psychologist who examined your child: _____

Address: _____

Phone: _____

Date of examination: _____

Who referred your child for examination? _____

Date of follow-up conference with the examining psychologist: _____

What tests were given? _____

Did the psychologist evaluate your child in these ability areas? What did he find?

1. Gross Motor Skills: (large muscle coordination & physical strength) _____

2. Sensory Motor Skills: (balance, motor accuracy, directionality, laterality) _____

3. Perceptual Skills: auditory: _____

visual: _____

visual-motor: _____

PSYCHOLOGICAL INFORMATION

Page 2

4. Language Development Skills: (vocabulary, reading, writing, spelling) _____

5. Conceptual Skills: (arithmetic, information, comprehension) _____

6. Social Skills: (ability to relate, self-control) _____

What recommendations were made concerning your child's school placement? _____

What recommendations were made to you (such as behavior modification, parent education, family counseling, medical supervision)? _____

What have you done about these recommendations? _____

Does the psychologist want to see your child again? _____

When? _____

This is a form to be filled out after your
handicapped child is seen by professionals
who will provide him with special services.

FORM 8:
SPECIAL SERVICES INFORMATION



SPECIAL SERVICES INFORMATION

Page 1

Type of professional seen: _____

Date of visit: _____

Name: _____

Address: _____

Phone: _____

Reason for examination: _____

Who referred you for this examination? _____

Date of follow-up conference: _____

What evaluative measures were used? _____

Results of examination: _____

Recommendations regarding school placement: _____

Recommendations regarding home programming: _____

What have you done about these recommendations? _____

SPECIAL SERVICES INFORMATION

Page 2

Is a repeat visit necessary? _____ When? _____

Why? _____

Did you follow up on the repeat visit? _____

SPECIAL SERVICES INFORMATION

Page 1

Type of professional seen: _____

Date of visit: _____

Name: _____

Address: _____

Phone: _____

Reason for examination: _____

Who referred you for this examination? _____

Date of follow-up conference: _____

What evaluative measures were used? _____

Results of examination: _____

Recommendations regarding school placement: _____

Recommendations regarding home programming: _____

What have you done about these recommendations? _____

SPECIAL SERVICES INFORMATION

Page 2

Is a repeat visit necessary? _____ When? _____

Why? _____

Did you follow up on the repeat visit? _____

SPECIAL SERVICES INFORMATION

Page 1

Type of professional seen: _____

Date of visit: _____

Name: _____

Address: _____

Phone: _____

Reason for examination: _____

Who referred you for this examination? _____

Date of follow-up conference: _____

What evaluative measures were used? _____

Results of examination: _____

Recommendations regarding school placement: _____

Recommendations regarding home programming: _____

What have you done about these recommendations? _____

SPECIAL SERVICES INFORMATION

Page 2

Is a repeat visit necessary? _____ When? _____

Why? _____

Did you follow up on the repeat visit? _____

**This form is an easy way for you to keep track
of the visits your handicapped child makes to
various professionals.**



Type of Professional	Name	Address	Phone	Date of Visit	Referred By	Purpose of Visit	Return visit recommended When?	Date of next appointment	Referred to: Name/ Specialty)

Type of Professional	Name	Address	Phone	Date of Visit	Referred By	Purpose of Visit	Return visit recommended When?	Date of next appointment	Referred to: Name/ Specialty)

Type of Professional	Name	Address	Phone	Date of Visit	Referred By	Purpose of Visit	Return visit recommended When?	Date of next appointment	Referred to: Name/ Specialty)

CALENDAR OF PROFESSIONAL CONTACTS